PART B

EMPLOYEE COMPLETES

Request for FMLA Leave

Employee Name _____

Address _____

City _____ *State* _____ *Zip Code* _____

Home Phone _____ *Work Phone* _____

Work Dept/Location _____ *Work Shift* _____

Supervisor _____

This request is due to:

❑ ***My own serious health condition.***

FAMILY LEAVE

❑ ***The serious health condition of a covered family member. Defined as parent, Child (including foster child), or spouse. In-laws covered under State FMLA only.***

a. Family member's name _____
b. Relationship _____
c. If employee's child, specify date of birth _____

❑ ***Birth*** (Medical Certification Not Required)

❑ ***Adoption*** (Court Documentation Required)

❑ ***Foster care placement*** (Court Documentation Required)
Not covered under State FMLA Law.

Indicate the Length of the Leave

Start Date _____ *End Date* _____

Return to Work Date _____

This two-page form must be returned directly to your HR representative.

Under the WFMLA, an employee may substitute any kind of paid accrued time for unpaid time for medical or family leave.

Under the federal FMLA, sick allowance may not be used for family leave due to birth of child or placement of a child for purposes of adoption or foster care.

Please specify dates you will be off and corresponding type of accrued time you are requesting to be used for each date.

Date(s)	Sick Allowance	Vacation	Holiday	Personal	Unpaid	Overtime (optional to use)

An absence due to a work related injury covered by Injury Pay or Worker's Compensation will be designated as a FMLA leave assuming you are eligible for FMLA leave.

I understand that if my requested time off is due to my serious health condition or that of a covered family member, I am required to submit to _____ _____, a completed FMLA Medical Certification by Health Care Provider Form within 15 days after I am requested to do so.

I also understand that if I fail to return to work at the end of my approved FMLA leave, I may be considered to have resigned in absentia. I may also be subject to discipline up to, and including, the filing of written charges for my discharge, if I fail to return from my leave.

_____ _____

Signature of Employee *Date*

Received by:

_____ _____

HR Representative *Date*

You will be notified of approval or disapproval of your request for FMLA leave in writing.

FMLA Medical Certification by Health Care Provider

PART C

PHYSICIAN COMPLETES

To be completed by Health Care Provider <u>Only</u>
(PLEASE PRINT LEGIBLY)

Dear Health Care Provider: Please fill out this form completely so that Milwaukee County may determine the employee's eligibility as defined under the Family and Medical Leave Laws.

Employee Name_____ **Patient Name** _____

1. Does the patient have a serious health condition (federal law definitions are on page 3)? ___Yes ___No

<u>If your answer is **No**, you may disregard the following request for further information.
Please sign and date this form on page 2.</u>

2. On what date did the current condition begin? _____
3. Date current condition ended or is expected to last _____
4. On what date do you expect the employee may return to work? _____
5. On what date(s) did you see the patient? _____
6. On what date(s) do you plan to see the patient? _____
7. If you saw the patient only once, did you prescribe any continuing treatment (for example, prescription drugs, therapy, referral to another health care provider)? _____ Yes _____ No
8. Type of continuing treatment: _____
9. Is the patient able to perform his/her employment duties? _____ Yes _____ No
10. Must the patient be absent from work for treatment? _____ Yes _____ No
11. Must the patient be absent from work in order to recover from the serious health condition? _____ Yes _____ No
12. Is the patient able to carry on other normal daily life activities? _____ Yes _____ No
13. Do not provide a diagnosis. Specify the medical facts related to this serious health condition, which currently prohibit the patient from working or carrying on other normal daily life activities.
_____
_____
_____

<u>MARK THIS FORM "CONFIDENTIAL" & FAX TO ONE OF THE FOLLOWING:</u>
<u>RETURN THIS ORIGINAL FORM TO THE EMPLOYEE</u>

<u>Fax #'s</u>:
Aging: ***Ara Garcia -- 289-8518***
Behavioral Health: ***Yvonne Makowski -- 257-5415***
House of Correction: ***Marlo Knox -- 427-8017***
Sheriff's Dept.: ***Minnie Linyear -- 223-1386***
Clerk of Courts: ***Jertha Ramos-Colon -- 223-1260***
Child Support Enforcement: ***Thea Flasch -- 223-1834***
DHHS: ***Candace Richards -- 257-5415***
DPPI & All Other Dept.: ***Gregory McKinstry -- 223-1930***
Zoo: ***Dave Meaux -- 256-5410***

14. Will it be necessary for the employee to work intermittently or to work less than a full time schedule due to the patient's condition? ______ Yes _____ No

    a. If yes, state the probable duration ____

15. Is the condition a chronic condition (see definition on page 3)? ______ Yes _____ No

    a. If yes, is the patient presently incapacitated? ______ Yes _____ No

16. If the patient has a chronic condition, what is the likely duration and frequency of episodes of incapacity? ____

17. If the patient requires additional treatments for the condition, provide an estimate of the probable number of such treatments ____

18. If the treatments will be provided on an intermittent basis, provide an estimate of the interval(s) between such treatments and the actual or estimated dates of treatment, if known, as well as the period required for recovery, if appropriate: ____
    ____

19. If the patient is a relative of the employee, please indicate if the employee is needed to provide psychological comfort to the patient or assist in the patient's recovery. ______ Yes ______ No

20. If the patient is a relative of the employee, please indicate the extent to which the employee is required to care for the patient. ____
    ____

________________________________	________________________________
Signature of Health Care Provider	Date
________________________________	________________________________
Print Name and Title of Health Care Provider	Telephone No.

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize the above-named health care provider to disclose my protected health information to Human Resources personnel of Milwaukee County for purposes of determining my eligibility for medical/family leave under the Wisconsin and/or Federal Family and Medical Leave Act(s).

This authorization permits disclosure of any portion of my protected health information, which is necessary to permit the designated health care provider to provide the most thorough responses possible to the inquiries in the foregoing FMLA Medical Certification Form.

This authorization will expire six months from the date this authorization is signed.

I understand that I have the right to revoke this authorization provided that such revocation is in writing, which shall be directed to ____, except to the extent that Milwaukee County has taken action in reliance on this authorization.

________________________________	________________________________
Employee or Patient Signature	Date

FMLA DEFINITIONS
UNDER FEDERAL LAW

A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

A period of incapacity[1] of more than three consecutive calendar days (including any subsequent treatment or period of incapacity[1] relating to the same condition), that also involves:

(1) Treatment[2] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

(2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[1] which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity[1] of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (d).

[1] "Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.

PART D

H.R. Manager/
Coordinator Completes

MILWAUKEE COUNTY
INTER-OFFICE COMMUNICATION

Date:

To:

From:

Subject: ***Response -- FMLA Approval Form***

This is to inform you that:

1. You **ARE** eligible for leave under federal and/or state FMLA laws for the following dates:_____

2. *Your FMLA leave time will be accounted for as follows:*

*Sick Allowance*_____ *Compensatory Time*_____

*Vacation*_____ *Holiday*_____

*Personal*_____ *Unpaid*_____

3. *Your leave time will be deducted from your annual (calendar year) FMLA leave entitlements as follows:*
_____

_____

4. *Your remaining annual FMLA entitlements after taking the current FMLA leave are:*

Under federal FMLA _____ *(weeks/days remaining)*

Under state FMLA _____ *(weeks/days remaining)*

5. If you are on an unpaid leave of absence during your FMLA leave, you will receive notice of payments for your portion of health insurance premiums due during your FMLA leave.

6. *You* ***ARE*** ***ARE NOT*** *required to furnish a statement from your health care provider indicating that you are able to resume working with/without restrictions before returning to work.*

7. You will return to work on _____.

8. You are required to notify _____ if you are unable
(Human Resources Manager/Designee)
to return to work on the date indicated above as soon as it becomes known to you.

By my signature below, I, _____, acknowledge receipt of
(Employee)
a copy of this two-page document and that I understand and agree to the terms set forth above.

_____ _____
Employee's Signature *Date*

CERTIFICATION – RETURN TO WORK

I have examined _____ and can certify that s/he is fully
(Employee)
able to return to work (with or without reasonable accommodations).

_____ _____
Health Care Provider's Signature *Date*